Health of the nation : a progress report / by the Comptroller and Auditor General.

NATIONAL AUDIT OFFICE

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

Health of the Nation: A Progress Report

HC 656 Session 1995–96
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John Bourn
Comptroller and Auditor General

National Audit Office
28 June 1996

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Contents

Preface

The government's Health of the Nation strategy, led and co-ordinated by the Department of Health, is the central plank of government policy on health in England and forms the main context for the planning of services provided by the NHS into the next millennium[1]. This report describes the background to the development of the Health of the Nation Strategy, providing an overview of progress towards the targets adopted as part of the initiative. It does not examine wider issues, such as what benefits have been gained at what cost.

The Health of the Nation is a wide-ranging strategy which aims to put health and health promotion on everyone's agenda. The strategy is set against the background of a continuing overall improvement in England's general state of health. It emphasises disease prevention and health promotion as ways in which even greater improvements in health can be secured, while acknowledging that further improvements in treatment, care and rehabilitation remain essential. The strategy emphasises the role of joint working, for example between government departments, local authorities and voluntary organisations. Within its five key areas there are 27 specific, quantified targets designed as tools to focus effort and to provide a measure to indicate progress. This report concentrates on progress towards those 27 targets.

1 *Priorities and Planning Guidance 1996-97*; Department of Health, 1995

Part 1: Strategy and development

Development of the Health of the Nation strategy

1 In 1991 the government published a Green Paper, *The Health of the Nation*[2] which set out a strategic approach to improving the health of the people of England. Drawing on the work of the World Health Organisation's *Health for All* strategy and on ideas from other countries, the Green Paper suggested that improvements in the nation's health could be brought about by health promotion and disease prevention rather than solely through improvements in healthcare services. It proposed the establishment of a co-ordinated strategy for public health, which would aim to improve the health of the nation.

2 The *Health of the Nation* White Paper which followed in July 1992 developed this into an ambitious strategy for improving the health of the population. To focus attention where it was most needed and where it would deliver the best return, the strategy identified five key areas of ill-health. Those five areas were chosen because:

- they were major causes of premature death or avoidable ill-health;
- they were ones where effective interventions should be possible offering significant scope for improvement in health;
- it was possible to set objectives and targets in the areas and monitor progress towards them.

The five key areas and their main objectives are listed in Table 1.

The key areas, the main objectives, and their associated targets, are tools for achieving the wider strategic aim of the Health of the Nation. The strategy also identifies a number of settings such as schools, homes and workplaces where health promotion could be focused to good effect and emphasises the value of joint working; for

2 Details of publications are given in the Bibliography at the end of the report

Table 1: Health of the Nation key areas and main objectives

A	Coronary heart disease and stroke	To reduce the level of ill-health and death caused by coronary heart disease and stroke and the risk factors associated with them.
B	Cancer	To reduce death and ill health from breast cancer, lung cancer, cervical cancer and skin cancer.
C	Mental illness	To reduce ill health and death caused by mental illness.
D	HIV/AIDs and sexual health	To reduce the incidence of HIV infection and sexually transmitted diseases; to provide effective diagnosis and treatment for HIV and STDs; to provide effective family planning services and to reduce the number of unwanted pregnancies.
E	Accidents	To reduce ill health, disability and death caused by accidents.

Source: based on Health of the Nation pp 47, 67, 83, 94, 104

example, between the Health Education Authority, the media, employers and employees. The strategy aims to put health onto everyone's agenda by extending recognition of the wide range of influences on health and widespread responsibility for taking account of health.

3 In each key area, the Department of Health set out action plans and proposals for meeting the targets they had set including co-ordinating action by other government departments, as many target areas impact on more than one government department. The Department also established a framework for monitoring and reviewing progress towards the targets. As part of the monitoring process, the Department has produced two progress reports: *One Year On ...* in 1993 and *Fit for the Future* in 1995. The Health of Nation initiative was paralleled in Wales, with the publication of *The Strategic Intent and Direction* in 1991; in Scotland by *Health Education in Scotland: A National Policy Statement*, published in 1991 and followed by *Scotland's Health: A Challenge to Us All* published in 1992 and in Northern Ireland by *A Regional Strategy for Northern Ireland Health and Personal Social Services* in 1992.

4 Improving health through Health of the Nation has been a key strategic goal for the NHS since the launch of the White Paper in 1992 and has been highlighted in successive NHS Priorities and Planning Guidance. The strategy has influenced health authorities' plans to purchase health care to meet needs of local people, and is reflected in local programmes carried out by hospitals, community health units and primary health care teams.

5 The White Paper stated that Regional Health Authorities would encourage District and Family Health Service Authorities to shift the focus towards health promotion, including changing the balance of resources as necessary. Joint working with local authorities,

voluntary bodies, schools and others has also provided additional resource in terms of expertise and access to target audiences but this cannot be quantified in financial terms.

Health of the Nation: targets

6 The Health of the Nation White Paper identified a range of targets for the reduction of death and ill health in the key areas. The Department of Health monitors progress towards these targets through a variety of indicators, some of which directly reflect the primary targets themselves, and also through a range of supplementary indicators, including for example, the take up or coverage rates for screening for cervical or breast cancer.

7 Table 2 lists the targets set out in the White Paper in 1992. Appropriate indicators for monitoring progress were specified in the White Paper and set out in more detail in *Specification of National Indicators* published in 1992. Baselines were set for each indicator against which progress is monitored by the Department. For most indicators the baseline year chosen was 1990. The target dates were chosen to reflect the time needed before any change would be observable, though in some cases; for example, smoking among 11-15 year olds (B9), there were pre-existing targets. Full details are given in Part 2.

Progress towards the targets

8 Table 3 on page 6 provides an overview of the progress of the Health of the Nation strategy, by summarising the information available for each target set out in Part 2 of this report. Assessing whether or not progress is being made towards the target is a complex task which should be approached cautiously. For some targets trends are not clear, or little historical data are available or the target date is further into the future, making assessment difficult.

Key points

- **Many targets show encouraging progress**
  Table 3 shows good progress towards many of the Health of the Nation targets on present trends.

- **Progress towards some targets cannot be monitored at present**
  Table 3 shows that it is not yet possible to monitor progress towards targets C1 and C3. This limits assessment of progress in the key area of mental illness, where only one indicator, the death rate from suicide, can currently be monitored. However,

Table 2: Health of the Nation indicators and targets

Coronary heart disease and stroke	A1	To reduce death rates for coronary heart disease (CHD) in people under 65 by at least 40% by the year 2000.
	A2	To reduce death rates for CHD in people aged 65 to 74 by at least 30% by the year 2000.
	A3	To reduce death rates for stroke in people under 65 by at least 40% by the year 2000.
	A4	To reduce death rates for stroke in people aged 65 to 74 by at least 40% by the year 2000.
	A5/B6	To reduce prevalence of cigarette smoking in men 16 and over to no more than 20% by the year 2000.
	A5/B6	To reduce prevalence of cigarette smoking in women 16 and over to no more than 20% by the year 2000.
	A6	To reduce mean systolic blood pressure in the adult population by at least 5mm Hg by 2005.
	A7	To reduce the percentage of men aged 16-64 who are obese to no more than 6% by the year 2005.
	A7	To reduce the percentage of women aged 16-64 who are obese to no more than 8% by the year 2005.
	A8	To reduce the average percentage of food energy derived from saturated fatty acids to no more than 11% by 2005.
	A9	To reduce the average percentage of food energy derived from total fat to no more than 35% by 2005.
	A10	To reduce the proportion of men drinking more than 21 units of alcohol a week to 18% by 2005.
	A10	To reduce the proportion of women drinking more than 14 units of alcohol a week to 7% by 2005.
Cancer	B1	To reduce the death rate for breast cancer in the population invited for screening by at least 25% by the year 2000.
	B2	To reduce the incidence of invasive cervical cancer by at least 20% by the year 2000.
	B3	To halt the year on year increase in the incidence of skin cancer by the year 2005.
	B4	To reduce the death rate for lung cancer by at least 30% in men under 75 by the year 2010.
	B5	To reduce the death rate for lung cancer by at least 15% in women under 75 by the year 2010.
	B7	To ensure that at least a third of women smokers stop smoking at the start of pregnancy by the year 2000.
	B8	To reduce the overall consumption of cigarettes by at least 40% by the year 2000.
	B9	To reduce the prevalence of smoking among 11-15 year olds by at least 33% by 1994.
Mental illness	C1	To improve significantly the health and social functioning of mentally ill people.
	C2	To reduce the overall suicide rate by at least 15% by the year 2000.
	C3	To reduce the suicide rate for severely mentally ill people by at least 33% by the year 2000.
HIV/AIDS and sexual health	D1	To reduce the incidence of gonorrhoea among men and women aged 15-64 by at least 20% by 1995.
	D2	To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous four weeks by at least 50% by 1997 and a further 50% by the year 2000.
	D3	To reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000.
Accidents	E1	To reduce the death rate for accidents among children aged under 15 by at least 33% by the year 2005.
	E2	To reduce the death rate for accidents among young people aged 15-24 years by at least 25% by the year 2005.
	E3	To reduce the death rate for accidents among people aged 65 years and over by at least 33% by the year 2005.

Source: Health of the Nation

Table 3: Progress towards Health of the Nation targets

Code	Target	Progress towards target?
A1	CHD under 65 years	✓
A2	CHD 65-74 years	✓
A3	Stroke under 65 years	✓
A4	Stroke 65-74 years	✓
B1	Breast cancer 50-69 years	✓
B4	Lung cancer, men under 75 years	✓
C2	Suicide	✓
D1	Gonorrhoea	✓
E1	Accidents under 15 years	✓
E2	Accidents 15-24 years	✓
E3	Accidents 65 years and over	✓
A5/B6	Cigarette smoking - males	?✓
A5/B6	Cigarette smoking - females	?✓
A8	Energy from saturated fat	?✓
A9	Energy from total fat	?✓
B8	Cigarette consumption	?✓
D3	Conceptions under 16 years	?✓
A7	Obesity	✗
A10	Drinking - females	✗
B9	Smoking 11-15 years	✗
A6	Blood pressure	?
B2	Cervical cancer	?
B3	Skin cancer	?
B7	Giving up smoking in pregnancy	?
B5	Lung cancer in females under 75	*
A10	Drinking - males	*
C1	Mental illness	-
C3	Mental illness - suicide	-
D2	Drug misusers sharing needles	-

Key to last column:

✓ = Making substantial progress towards target
✗ = Moving in opposite direction to target
?✓ = Making some progress towards target
? = Not yet possible to assess progress in either direction
* = No significant change from baseline or no clear trend
- = No monitoring data consistent with baseline yet available nationally, so no assessment practicable

Source: National Audit Office analysis

work undertaken by the Department since the publication of the White Paper in 1992 means that it will now be possible to begin to monitor progress. Similar problems affect target D2, relating to the number of drug users sharing needles, which is an important factor in the spread of HIV amongst intravenous drug users.

- **The quantity and quality of data available are sometimes limited**
  For some targets, there are little current data and limited historical data available. It is therefore very difficult to make a meaningful assessment of recent progress or to set a meaningful target. Examples include the targets for giving up smoking in pregnancy (B7) and the target for the reducing mean systolic blood pressure in the adult population (A6).

  For other indicators, the quality of data available may be poor, because of limitations in data collection, or changes in the basis of calculation which make comparisons over time difficult. Data on cigarette consumption (B8) are affected by the recent impact of the EU Single Market which makes estimating consumption harder. Also, in 1993 the Office of Population Censuses and Surveys changed the way in which they record and code cause of death which means that data currently available from that year onwards are not strictly comparable with those for earlier years.

- **The timescale for measurement is often long**
  It is inevitable that some indicators will not respond quickly, even if the Health of the Nation strategy brought about immediate modifications in behaviour, since some diseases take many years to appear. In addition, there are substantial time lags before data are available for some indicators. For example, information from the Office of Population Censuses and Surveys for the incidence of cervical and skin cancer (indicators B2 and B3) in 1991 has not yet been published, though the systems of the Office of Population Censuses and Surveys and the regional cancer registry systems are undergoing major redevelopment which should lead to improvements in the information available. Similarly, data for monitoring the target for smoking cessation in women, before or during pregnancy (B7) are presently drawn from the OPCS Infant Feeding Survey, which takes place only every five years. These indicators cannot therefore be used to monitor changes over periods of time of less than several years and their usefulness in the short and medium term is limited.

- **Some targets appear to have been met already**
  Although there have been reversals of trends in the past, one target, D1, incidence of gonorrhoea, has already been met. Targets, E1 and E2, deaths from accidents, appear to have been met, but this cannot yet be confirmed. (See pages 41 to 43 of Part 2.)

Areas where progress is limited

9 The targets set in the White Paper were intended to be challenging but realistic. However, there are some areas in which it is clear that progress is limited.

- **Obesity (A7)**
  Obesity is an important risk factor in coronary heart disease, stroke and many other diseases such as diabetes. The target is to reduce the proportion of obese men and women in the population in 2005 to approximately 1980 levels. Given the strong upward trend over the 1980s, this would require approximately halving the current proportion of obese men and women in the population, aged 16-64. However, a rise in obesity between the 1986-87 baseline year and the publication of the White Paper in 1992 makes the target particularly challenging.

- **Saturated fatty acids and total fat in the diet (A8, A9)**
  A diet high in saturated fat increases the level of cholesterol in the blood, which is an important risk factor for coronary heart disease. The saturated fatty acids content of the average diet is declining slowly, as is the total fat content of the average diet. On the most recent rates of decline neither is dropping sufficiently to meet the targets set for 2005. However, the latest data are from 1994, the same year in which the strategy to achieve the targets was published (*Eat Well!*). This strategy is expected to take some years to show its effect and is due to be evaluated in 2000.

- **Drinking more than the sensible level of alcohol (A10)**
  Sustained alcohol consumption above the recommended sensible levels carries health risks. Following a review of the scientific and medical evidence, the Department has concluded that low to moderate drinking can protect against some diseases, in particular coronary heart disease and stroke. The review also revised the benchmarks for sensible drinking. The Department is considering the implications of these policy changes for the Health of the Nation targets. However, achieving the target for 2005 would require significant reductions against a background

where from 1984, when data became available, drinking above sensible levels by men showed no clear downward trend and grew for women.

- **Smoking among children aged 11-15 years (B9)**
  Smoking is an important risk factor for a wide range of diseases, particularly lung cancer. The target is to reduce by 33 per cent in 1994 the number of children aged 11-15 who smoke regularly compared against the 1988 baseline. In fact, instead of falling, the proportion of children who smoke has risen by 50 per cent (from 8 to 12 per cent) since 1988, the baseline year. This is a matter of concern even though, with hindsight, the baseline year 1988 was a low point.

The impact on the nation's health: conclusions and recommendations

10 The Department of Health has invested time and resources in setting the strategy, developing indicators and frameworks, and initiating actions designed to help achieve the strategy's objectives. A small team produced the Green and White Papers and launched the strategy with a series of regional conferences. Since then the team has worked centrally to maintain and coordinate the strategy and to develop its public profile. Health authorities have made considerable use of the Health of the Nation key areas in deciding how best to use their resources in healthcare provision and health promotion. The effect of the initiative on the NHS as a whole has been substantial.

11 The Health of the Nation initiative is an ambitious and far-reaching strategy to improve the health of the people of England. Co-ordinated action between the Department of Health and other departments will continue to be essential if the most is to be gained from the initiative. Health of the Nation is steered at the highest level by a Cabinet Subcommittee, (EDH(H)), chaired by the Lord President of the Council and members are drawn from a wide range of interested Departments. Members include for example the Minister of Agriculture, Fisheries and Foods and the Secretaries of State for Environment and Transport. The commitment to cross government working was underlined with the publication of *Policy Appraisal and Health* in 1995, which was aimed particularly at non-health agencies.

12 The *Health of the Nation* White Paper stated that, "the sole measure of its success will be what it contributes to the achievement of these targets and others which are developed over time"[3]. The Department has published two progress reports: *One Year On ....* in 1993 and *Fit for the Future* in 1995. The latter identified action to be taken to address areas where progress was not being made; for example, obesity. Among other initiatives, health education campaigns are planned to address both obesity and teenage smoking. The Chief Medical Officer's Health of the Nation Working Group meets regularly to discuss the progress towards targets.

13 It is too soon to say how far the Health of the Nation strategy will ultimately succeed. It is clear that in some areas a further review of progress and the development of new action plans for the future are needed.

The Department of Health should continue to address:

- those areas where targets have already been met and areas where good progress is being made, with a view to considering whether it is desirable for targets to be revised within the existing framework, in order to maximise the effectiveness of the initiative and its value for money;

- those areas where progress is slow, or trends are running counter to targets to see what further action should be taken;

- the need to improve the quality, availability and timeliness of data generally and in the mental health area in particular.

14 The rest of this report sets out a structured summary of each indicator, its context, how it is measured, the target, and, on a consistent basis, the available data on the movement of the indicator, both before the Health of the Nation strategy was launched and since. It also provides a short commentary on trends for each indicator.

3 *Health of the Nation HMSO 1992, page 43*

Part 2: Progress towards targets

The data presented for each target in this report have been provided by the Central Health Monitoring Unit of the Department of Health. The analysis for the report was undertaken by the Health Services Management Centre at the University of Birmingham, using the data supplied by the Department of Health. For all indicators based on death rates, the way in which the cause of death is recorded and coded by the Office of Population Censuses and Surveys (OPCS) changed in 1993. This means that data for these indicators from 1993 onwards are not strictly comparable with those for earlier years, nor indeed with baseline and target figures. The break in the data is shown by a dotted line on each mortality graph. Changes in these indicators need to be interpreted with caution. The Department of Health's second report on progress on the Health of the Nation strategy, *Fit for the Future*, included a commitment to produce a technical supplement clarifying these questions.

Assessing the extent of progress towards the targets is a complex task, which should be approached with some caution. In some cases, clear trends exist which can be extrapolated, taking into account data from other sources such as international comparisons and the movement of other indicators. However, where trends are less clear, little historical data are available, or the time period to the target date is longer, it has not always been possible to make meaningful judgements about movement towards the targets.

Indicator

A1

Deaths from coronary heart disease in people aged under 65

Background

Coronary heart disease (CHD) results from narrowing of the arteries and stiffening of their walls by hard fatty deposits. This reduces blood supply to the heart muscle, and eventually the heart muscle becomes short of blood. This may lead to angina, heart attacks, disturbances of heart rhythm and heart failure. CHD is the cause of 24 per cent of all deaths in England, which makes it by far the commonest single cause of death. England has one of the highest rates of CHD in the world, and it has been estimated that the NHS spends £500 million each year on treating CHD. Much of the ill-health and mortality resulting from CHD could be prevented by reducing smoking, taking more exercise, reducing the fat content of the diet, and identifying and treating people with hypertension.

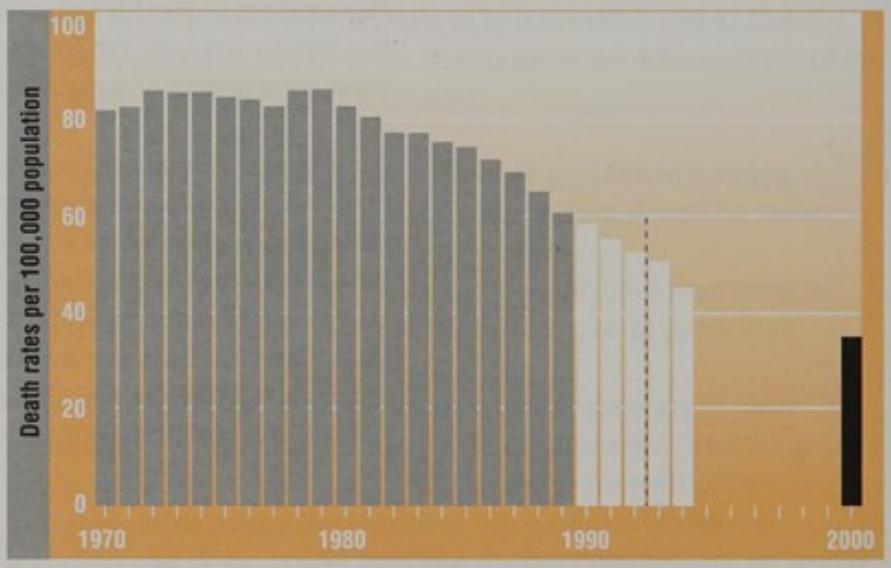
Target

To reduce the death rate from coronary heart disease in people under 65 by at least 40 per cent by the year 2000, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
58.6	45.4	35.1

Comments

Death rates from coronary heart disease in people under 65 have been falling steadily since 1979, and have continued to do so at about the same rate since the Health of the Nation initiative commenced. A similar fall, starting rather earlier, has been observed in other countries.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

A2

Deaths from coronary heart disease in people aged 65-74 years

Background

Coronary heart disease is by far the commonest single cause of death in England. Death rates from CHD increase steeply with age.

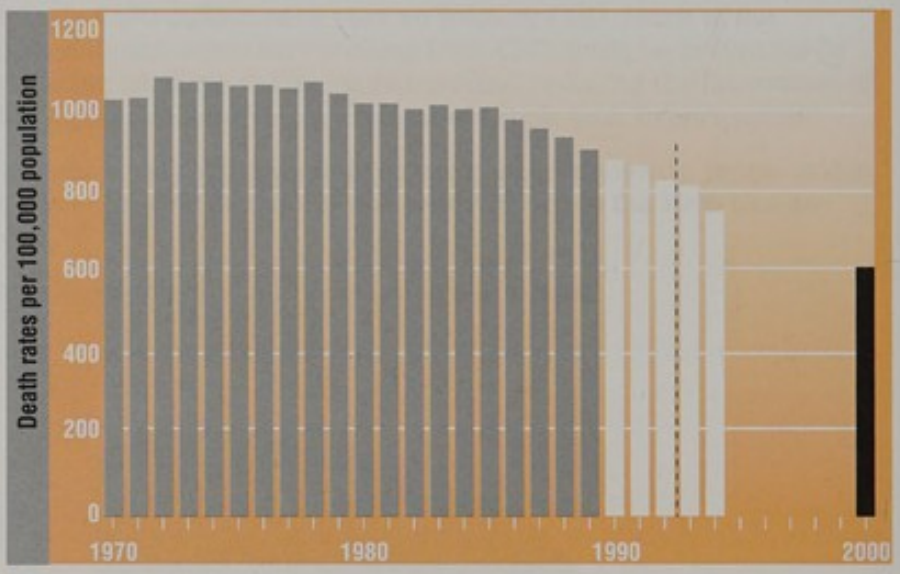
Target

To reduce the death rate from coronary heart disease in people aged 65-74 years by at least 30 per cent by the year 2000, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
889	761	623

Comments

Death rates from coronary heart disease in people aged 65-74 years have been falling steadily since 1985, like those for people in younger age ranges both in England and elsewhere. Since the commencement of the Health of the Nation initiative, this decline has continued at about the same rate. The reduction is probably attributable to long term changes in diet and behaviour and improvements in the medical treatment of people with CHD.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

A3

Deaths from strokes in people aged under 65

Background

A stroke is a disturbance of brain function usually caused by a blood clot or bleeding into brain tissue. Strokes cause about 12 per cent of all deaths in England. About 30 per cent of people who have a stroke die within a few weeks. Of the remainder, about half will have significant continuing disabilities. It has been estimated that 4.5 per cent of the NHS budget or about £1.6 billion is used in treating, rehabilitating and providing long term care for people with strokes. Strokes can be prevented particularly by identifying and treating people with hypertension who are at a higher risk of stroke.

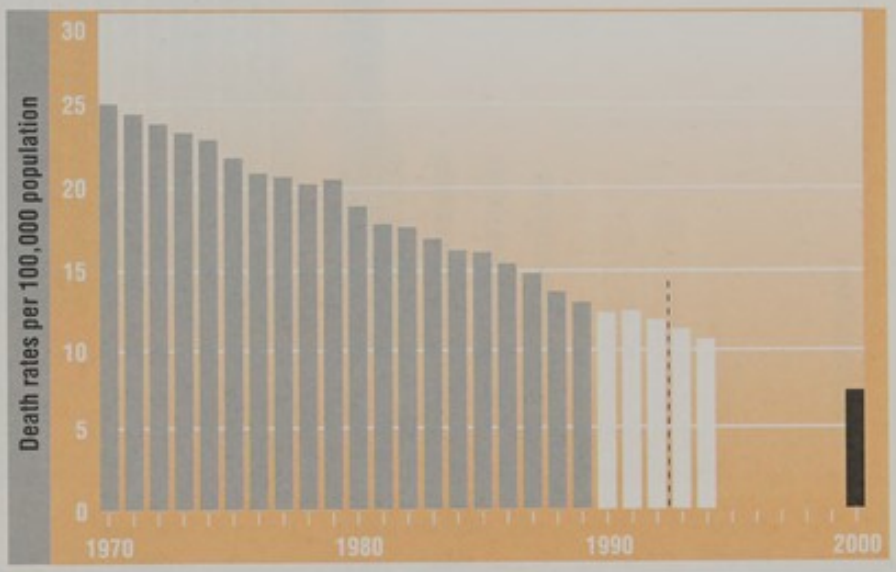
Target

To reduce the death rate from stroke in people aged under 65 by at least 40 per cent by the year 2000, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
12.3	10.6	7.4

Comments

Death rates from stroke in people under 65 have been falling steadily since 1970, and have continued to do so at about the same rate since the Health of the Nation initiative was launched. It is likely that this reflects improvements in general vascular health, changes in behaviour and diet. Also innovations in the medical treatment of people with stroke have improved rehabilitation and secondary prevention.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

A4

Deaths from strokes in people aged 65-74 years

Background

A stroke is a disturbance of brain function usually caused by a blood clot or bleeding into brain tissue. Strokes can be prevented by identifying and treating people with hypertension.

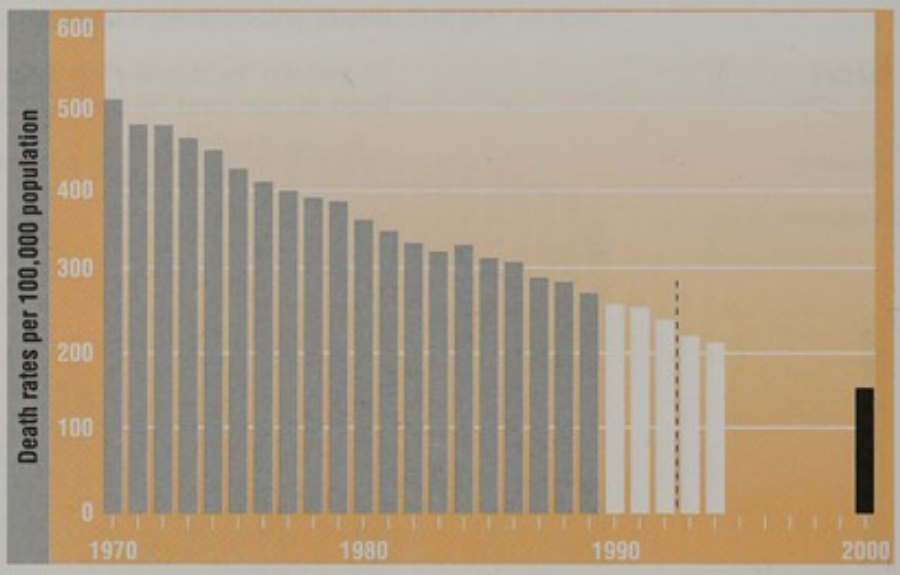
Target

To reduce the death rate from stroke in people aged 65-74 years by at least 40 per cent by the year 2000, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
259.5	212.0	155.7

Comments

Death rates from stroke in people aged 65-74 years have been falling steadily since 1970, and have continued to do so at about the same rate since the Health of the Nation initiative was launched. It is likely that this reflects improvements in general vascular health, changes in behaviour and diet, as well as innovations in the medical treatment of people with stroke which have improved rehabilitation and secondary prevention.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

A5/B6

Cigarette smoking in men aged 16 years or over

Background

Smoking is an important risk factor for a wide range of diseases. For example, it is estimated that smoking is responsible for at least 80 per cent of deaths from lung cancer, 18 per cent of deaths from coronary heart disease, and 11 per cent of deaths from strokes. This ill-health and mortality can largely be prevented if people stop smoking or do not start smoking in the first place.

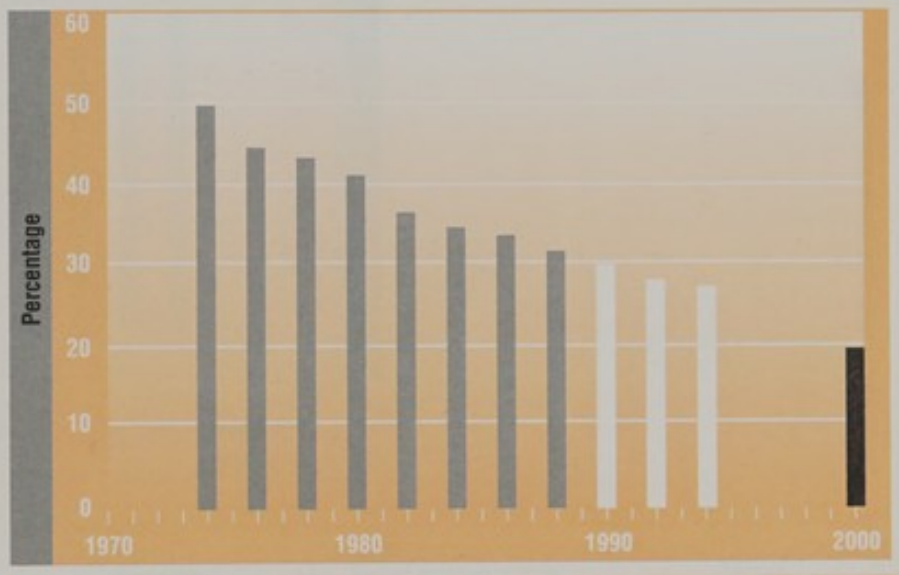
Target

To reduce the prevalence of cigarette smoking among men aged 16 years or over to no more than 20 per cent by the year 2000.

Measure

Percentage of men aged 16 years or over who smoke regularly.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
31	28	20

Comments

The prevalence of smoking among men has been falling steadily since 1974. This probably reflects long term changes in awareness about the health risks of smoking and in social attitudes. Because little data are available after 1990, it is difficult to tell whether that decline has continued since the Health of the Nation initiative began. However, there may well be a hard core of smokers, who are resistant to change and progress may slow.

Technical notes

Data have been drawn from the annual OPCS General Household Survey, in which questions about smoking are asked every second year. Directly comparable data on smoking prevalence are not available prior to 1974. This target is relevant to the key areas of CHD, stroke and cancer.

Indicator

A5/B6

Cigarette smoking in women aged 16 years or over

Background

Smoking is an important risk factor for a wide range of diseases.

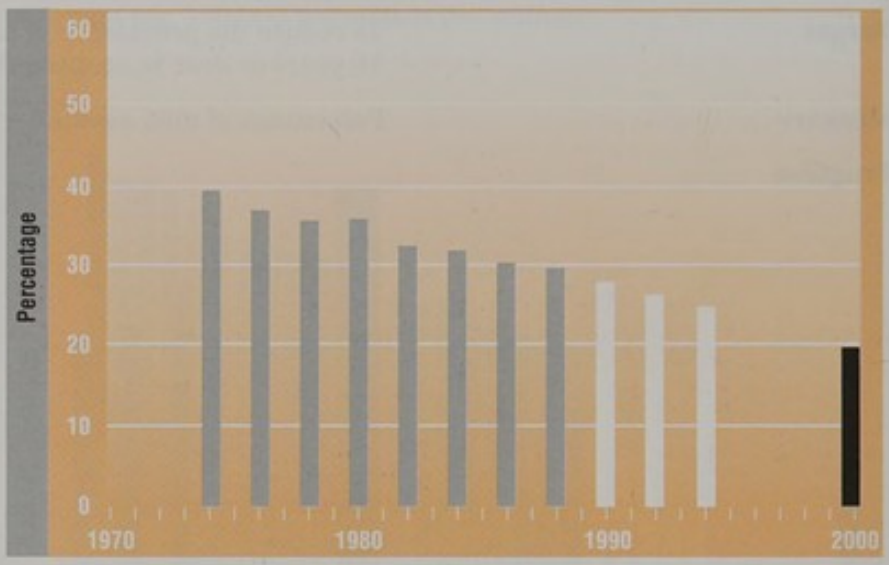
Target

To reduce the prevalence of cigarette smoking among women aged 16 years or over to no more than 20 per cent by the year 2000.

Measure

Percentage of women aged 16 years or over who smoke regularly.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
28	25	20

Comments

The prevalence of smoking among women has been falling steadily ever since 1974. Although fewer women than men smoke, the rate of decline in smoking among women is somewhat slower than that seen among men. Again, the decline probably reflects long term changes in awareness about the health risks of smoking and in social attitudes. Because little data are available after 1990, it is difficult to tell whether that decline has continued since the Health of the Nation initiative began. However, there may well be a hard core of smokers, who are resistant to change and progress may slow.

Technical notes

Data have been drawn from the annual OPCS General Household Survey, in which questions about smoking are asked every second year. Directly comparable data on smoking prevalence are not available prior to 1974. This target is relevant to the key areas of CHD, stroke and cancer.

Indicator

A6

Mean systolic blood pressure in the adult population

Background

High blood pressure (hypertension) is a known risk factor for both coronary heart disease (CHD) and stroke. The causes of high blood pressure include excess alcohol consumption, obesity and excess salt in the diet.

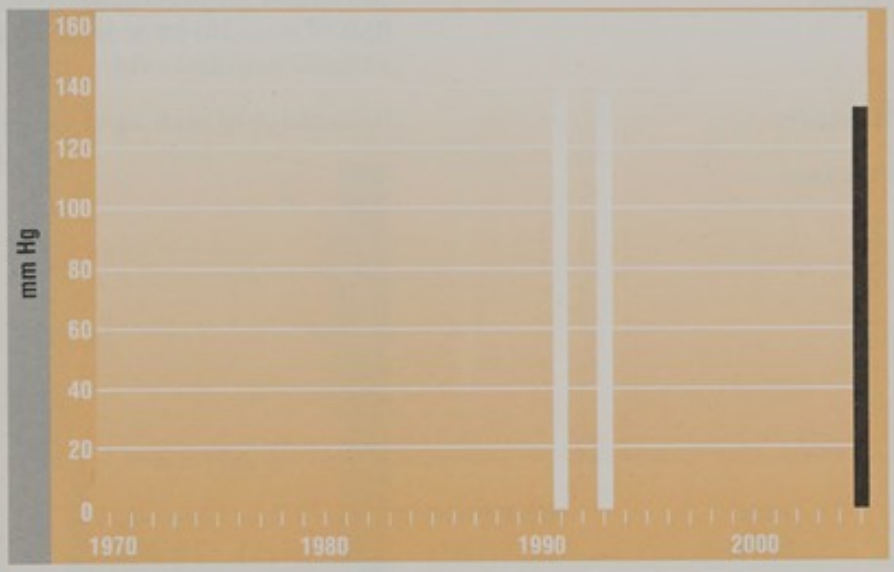
Target

To reduce the mean systolic blood pressure in the adult population by at least 5mmHg by the year 2005, from the 1991/92 baseline rate.

Measure

Mean systolic blood pressure, in mmHg.

Progress



Baseline (1991/92)	Latest available data (1993)	Target (2005)
138	137	133

Comments

The slight change in mean blood pressure between 1991/92 and 1993 is not significant. Because of the limited information available, it is not yet possible to tell what progress is being made.

Technical notes

Data have been drawn from the OPCS Health Survey for England which was first undertaken in 1991. The samples in 1991 and 1992 were small which is why they have been combined. There are no historical data available before 1991.

Indicator

A7

Obesity among men aged 16-64

Background

Obesity is a risk factor in both coronary heart disease and stroke, and is associated with increased morbidity and mortality in many other diseases. All obesity results from a dietary energy intake chronically in excess of energy expenditure and is made more likely by a diet rich in fat combined with a lack of physical activity. Obesity is measured by the Body Mass Index (BMI) calculated from a person's height and weight, and is defined as a BMI of over 30. (BMI is calculated by dividing weight in kilograms by height in metres squared.)

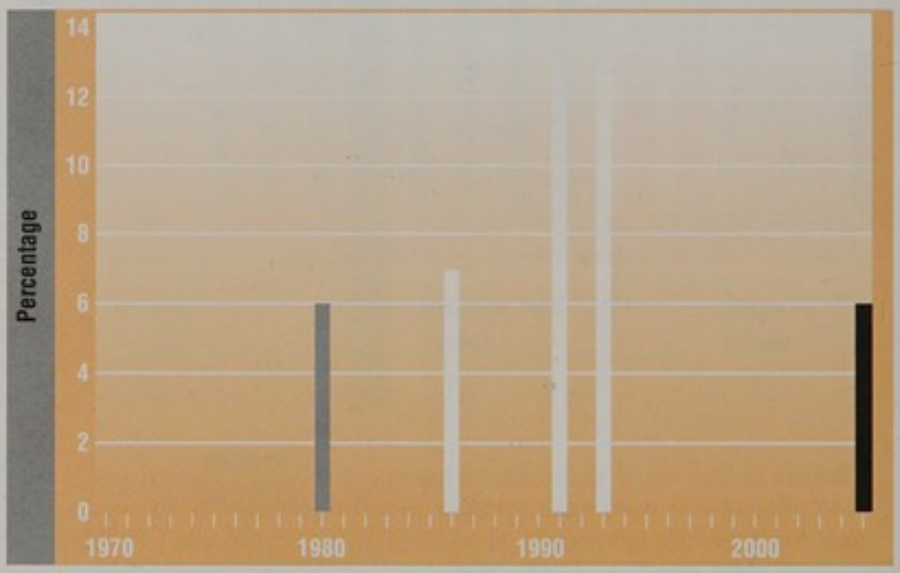
Target

To reduce the percentage of men aged 16-64 who are obese (with a BMI of over 30) by at least 25 per cent by the year 2005, from the 1986/87 baseline rate.

Measure

Percentage of men aged 16-64 years, classified as obese.

Progress



Baseline (1986/87)	Latest available data (1993)	Target (2005)
7	13	6

Comments

From the limited available data, it seems that the prevalence of obesity in the population is increasing rather than declining.

Technical notes

Data have been drawn from the OPCS Health Survey for England and two other past surveys. No comparable data before 1980 are available.

Indicator

A7

Obesity among women aged 16-64

Background

Women are more likely to be obese than men.

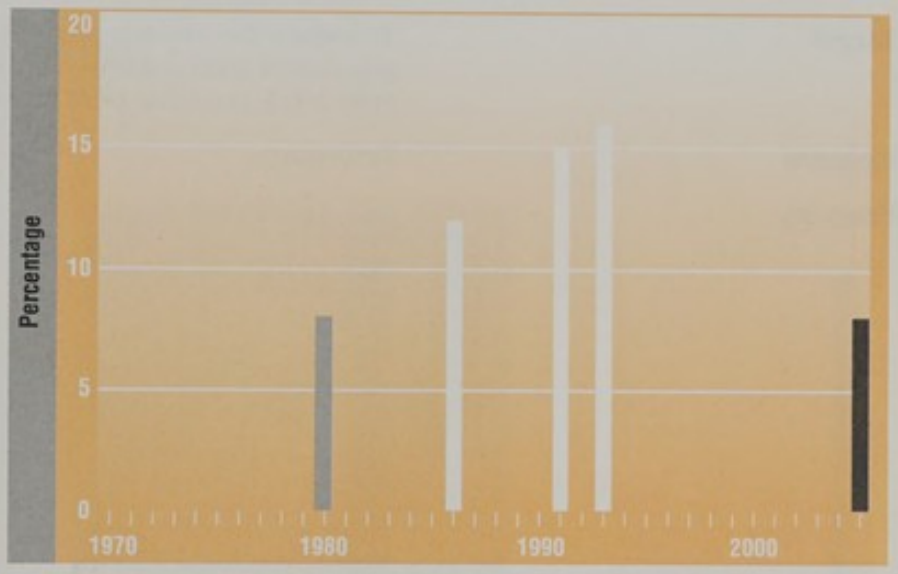
Target

To reduce the percentage of women aged 16-64 who are obese (with a BMI of over 30) by at least 33 per cent by the year 2005, from the 1986/87 baseline rate.

Measure

Percentage of women aged 16-64 years, classified as obese.

Progress



Baseline (1986/87)	Latest available data (1993)	Target (2005)
12	16	8

Comments

From the limited available data, it seems that the prevalence of obesity in the population is increasing rather than declining.

Technical notes

Data have been drawn from the OPCS Health Survey for England and two other past surveys. No comparable data before 1980 are available.

Indicator

A8

Percentage of food energy derived from saturated fatty acids

Background

The dietary intake of fats influences the level of plasma cholesterol, which is an important determinant of the risk of coronary heart disease. Plasma cholesterol levels are high in the UK in comparison to other countries, just as the incidence of coronary heart disease is higher here. Reducing the dietary intake of fats should also reduce obesity, and contribute to preventing other diseases such as strokes.

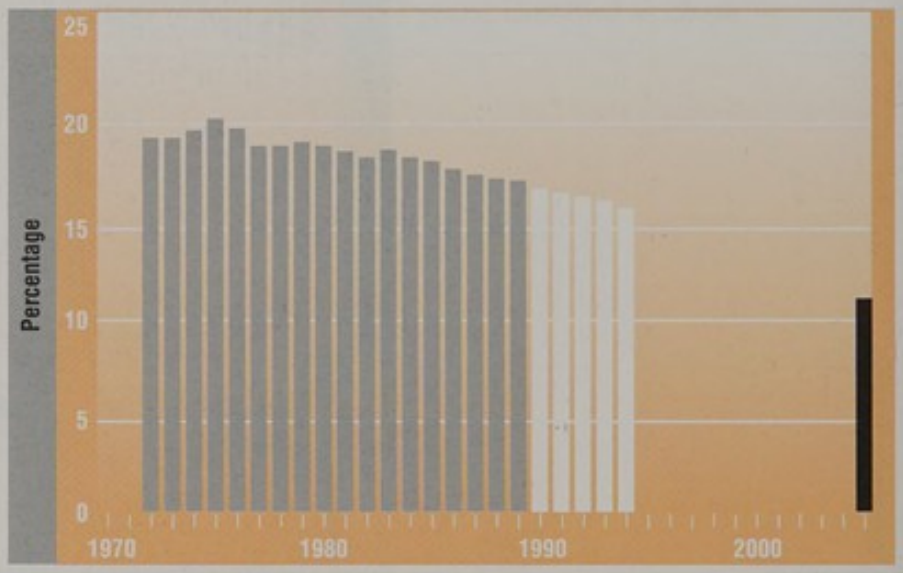
Target

To reduce the average percentage of food energy derived by the population from saturated fatty acids by at least 35 per cent by the year 2005, from the 1990 baseline level.

Measure

Percentage.

Progress



Baseline (1990)	Latest available data (1994)	Target (2005)
16.7	15.7	11

Comments

The proportion of energy derived from saturated fatty acids by the general population has been falling gradually but steadily since 1975, and has continued to do so at about the same rate since the Health of the Nation initiative commenced. This probably reflects a long term growing awareness of the benefits of a lower fat diet. Action proposed by the Nutrition Task Force could have an effect by 1998-99 and relevant data would be published in the following year.

Technical notes

Data have been drawn from the MAFF National Food Survey.

Indicator

A9

Percentage of food energy derived from total fat

Background

The dietary intake of fats influences the level of plasma cholesterol, which is in turn an important risk factor in coronary heart disease. Reducing dietary intake of fats should also reduce obesity, and contribute to preventing other diseases such as strokes.

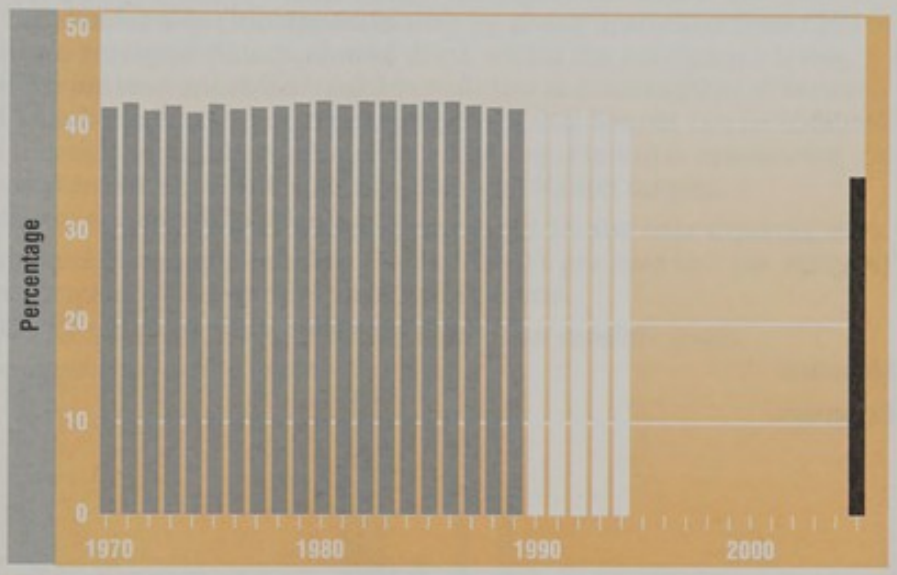
Target

To reduce the average percentage of food energy derived by the population from total fats by at least 12 per cent by the year 2005, from the 1990 baseline level.

Measure

Percentage.

Progress



Baseline (1990)	Latest available data (1994)	Target (2005)
41.6	40.5	35

Comments

The proportion of energy derived from total fats has changed little over the last twenty years, though a small but consistent decline has occurred since 1986 and the trend has continued at about the same rate since the Health of the Nation initiative was launched. Action proposed by the Nutrition Task Force could have an effect by 1998/99 and the relevant data would be published in the following year.

Technical notes

Data have been drawn from the MAFF National Food Survey.

Indicator

A10

Proportion of men aged 18 and over drinking more than 21 units of alcohol per week

Background

Sustained drinking above recommended sensible levels causes raised blood pressure and contributes to the risk of coronary heart disease and stroke. It is also associated with many other diseases, such as liver cirrhosis and some cancers, and causes alcohol-related road traffic accidents. When this target was set, the appropriate level for men was set at no more than 21 units per week. Following the report of an Interdepartmental Working Group, a benchmark of between 3 and 4 units per day has been set for men. Consistently drinking 4 or more units per day carries a progressive health risk, although the report concluded that alcohol can confer a health benefit, mainly by giving protection from CHD to men over 40 who drink within the benchmark levels. The maximum overall health benefit lies at consumption of between 1 and 2 units per day; the major part of that benefit can be obtained at levels as low as 1 unit per day. The Department is considering the implications of this for the Health of the Nation targets.

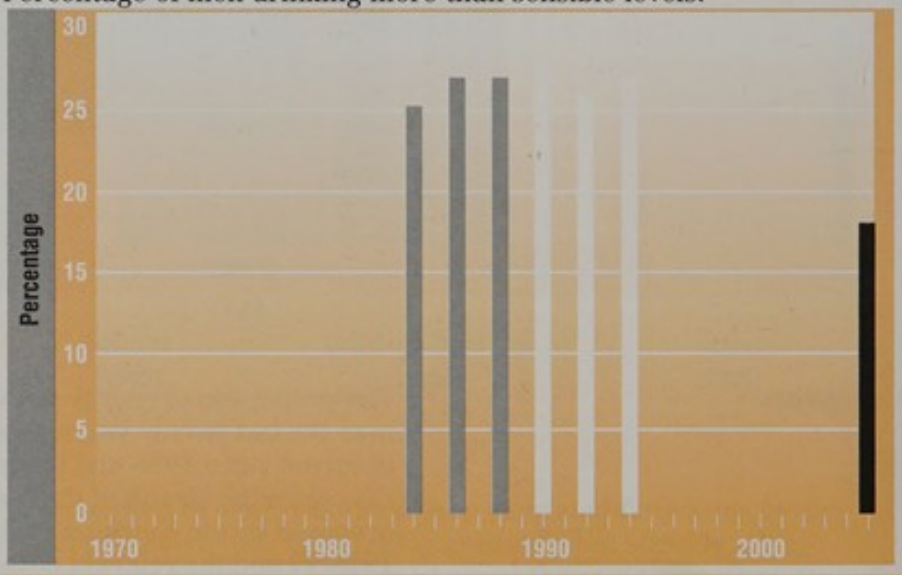
Target

To reduce the proportion of men aged 18 and over drinking more than 21 units of alcohol per week from 28 per cent to 18 per cent by the year 2005, from the 1990 baseline rate.

Measure

Percentage of men drinking more than sensible levels.

Progress



Baseline (1990)	Latest available data (1994)	Target (2005)
28	27	18

Comments

The percentage of men drinking over 21 units of alcohol per week has fluctuated over the brief period for which data is available, but there is no clear trend. The fluctuations have continued since the baseline figure in 1990; in 1994 the difference from the baseline is not statistically significant.

Technical notes

Data for years before 1984 are not readily available on a consistent basis.

Indicator

A10

Proportion of women aged 18 and over drinking more than 14 units of alcohol per week

Background

Sustained drinking in excess of sensible levels causes raised blood pressure and contributes to the risk of stroke. It is associated with other diseases, like liver cirrhosis and some cancers, and causes alcohol-related road traffic accidents. When this target was set, the appropriate level for women was set at no more than 14 units per week. Following the report of an Interdepartmental Working Group, a benchmark of between 2 and 3 units per day has been set for women. Consistently drinking 3 or more units per day carries a progressive health risk, although the report concluded that alcohol can confer a health benefit, mainly by giving protection from CHD to post-menopausal women who drink within the benchmark levels. The maximum overall health benefit lies at consumption of between 1 and 2 units per day; the major part of that benefit can be obtained at levels as low as 1 unit per day. The Department is considering the implications of this for the Health of the Nation targets.

Target

To reduce the proportion of women aged 18 and over drinking more than 14 units of alcohol per week from 11 per cent to 7 per cent by the year 2005, from the 1990 baseline rate.

Measure

Percentage of women drinking more than sensible levels.

Progress

Baseline (1990)	Latest available data (1994)	Target (2005)
11	13	7

Comments

The percentage of women drinking over 14 units of alcohol per week has gradually increased over the brief period for which data are available. The change to 1994 is statistically significant, so there is an upward trend away from the target.

Technical notes

Data for years before 1984 are not readily available on a consistent basis.

Indicator

B1

Deaths from breast cancer in women aged 50-69 years

Background

Breast cancer is the leading cause of death from cancer among women over 35 in England, responsible for about 19 per cent of all cancer deaths in this group. One in twelve of all women will develop breast cancer at some point in her life. While the incidence varies internationally, many countries have seen a slow increase over the last thirty years. If breast cancer can be identified early, through screening or self-examination, treatment with surgery, radiotherapy and chemotherapy is much more likely to result in long term survival.

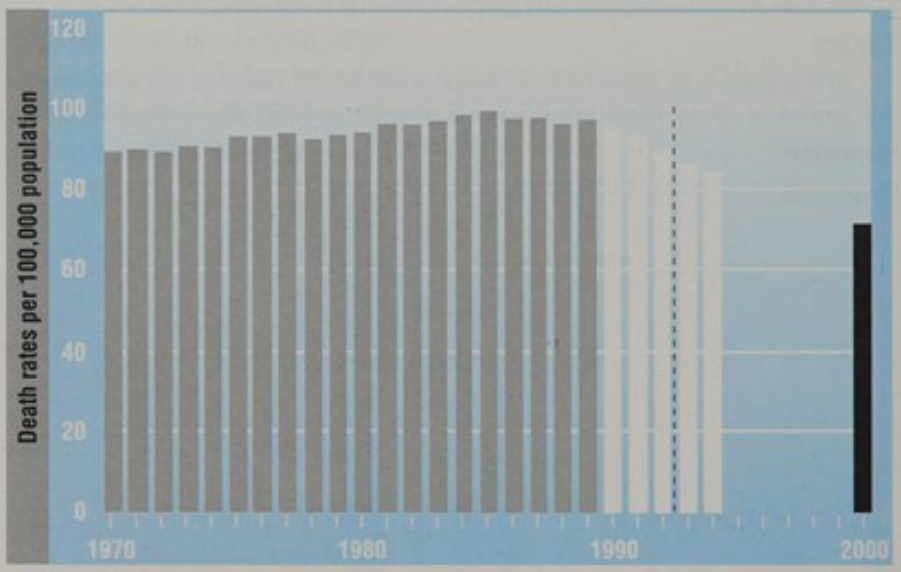
Target

To reduce the death rate from female breast cancer in the population invited for screening by at least 25 per cent by the year 2000, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
95.1	84.3	71.3

Comments

Death rates from breast cancer rose slowly but consistently until 1985, when they levelled off before starting to fall in 1990 just before the Health of the Nation initiative started. Since then, rates have continued to fall and good progress continues. The Health of the Nation target has been set for a wider age group (women aged 50-69 years) than the population invited for screening (women aged 50-64 years) to enable the longer term impact of the screening programme on mortality reduction to be assessed.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

B2

Incidence of invasive cervical cancer

Background

There are about 4,300 cases of invasive cervical cancer each year in England and Wales, and about 1,500 deaths from the disease. The incidence and death rate can both be reduced by screening women at risk of developing the disease, identifying those who show pre-cancerous changes, and treating them to prevent the disease developing.

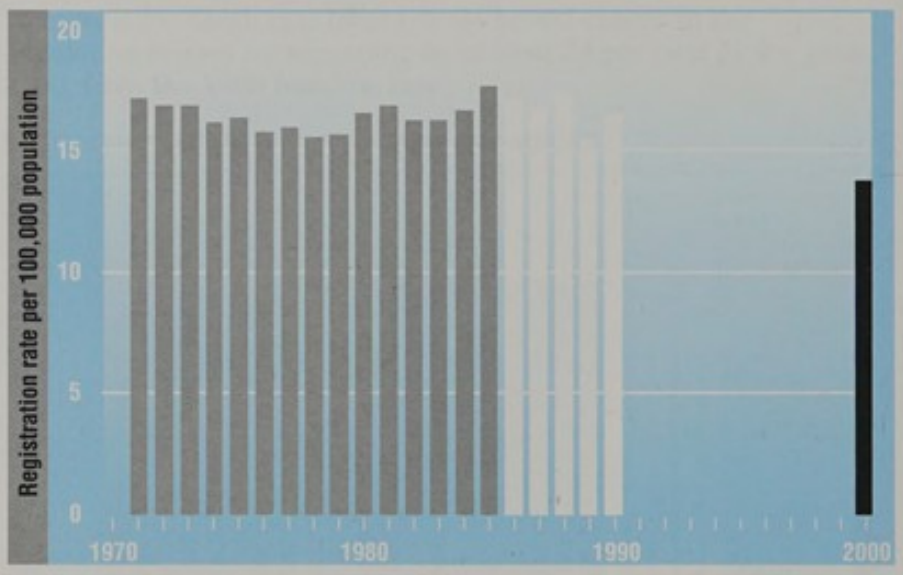
Target

To reduce the incidence of invasive cervical cancer by at least 20 per cent by the year 2000, from the 1986 baseline rate.

Measure

Registration rate per 100,000 population per annum.

Progress



Baseline (1986)	Latest available data (1990)	Target (2000)
17.2	16.6	13.8

Comments

No consistent trend is evident in the incidence of cervical cancer. Since no data are available after 1990, the impact of the Health of the Nation initiative cannot yet be assessed.

Technical notes

Data have been drawn from OPCS statistics and age-standardised. No data are yet available after 1990. It should be noted that the target and baseline shown above are based on the latest available incidence data for 1986, and therefore differ from those published in the Health of the Nation White Paper and subsequent reports. Available data predate the start of the Health of the Nation strategy. Registration rates are used as a proxy for incidence rates.

Indicator

B3

Incidence of skin cancer

Background

The incidence of skin cancer has been rising sharply in recent years. There are now about 35,000 cases of skin cancer each year in England and Wales, and about 1,800 deaths from the disease. An important risk factor is excessive exposure to ultraviolet (UV) radiation from the sun and other, man-made sources. It is estimated that four out of five skin cancers can be prevented by reducing exposure to UV radiation, especially by avoiding sunburn and using sun protection. The death rate, too, can be reduced through greater awareness of the disease, leading to earlier reporting of suspicious lesions at a stage at which they are still treatable.

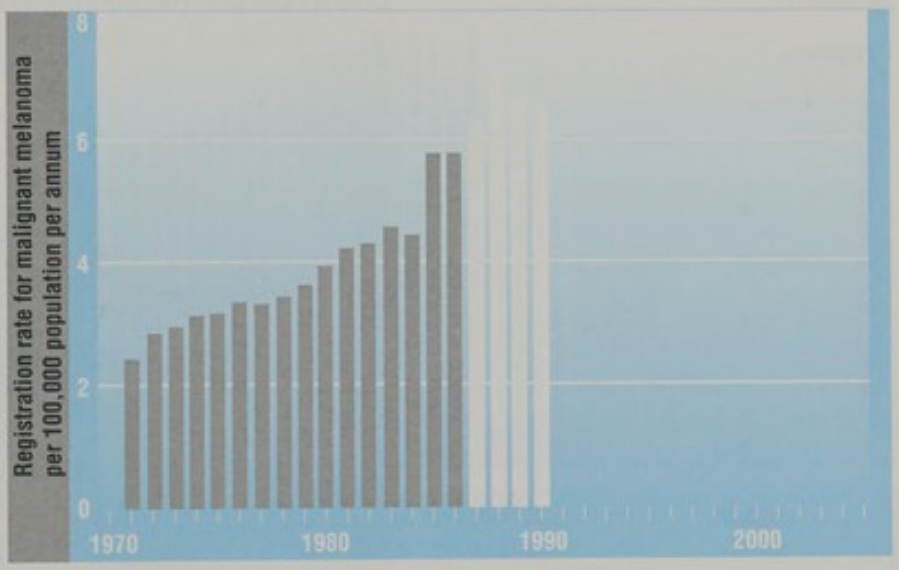
Target

To halt the year on year increase in the incidence of skin cancer by the year 2005.

Measure

Registration rate per 100,000 population per annum.

Progress



Baseline (1986)	Latest available data (1990)	Target (2005)
5.8	6.6	n/a

Comments

The incidence of skin cancer has been rising consistently since 1971, and has nearly tripled over the last twenty years. The target is to halt the year on year rise rather than to achieve any particular incidence rate, and so it is difficult to assess progress.

Technical notes

Data have been drawn from OPCS statistics and age-standardised. No data are yet available after 1990. Available data predate the start of the Health of the Nation strategy. Registration rates are used as a proxy for incidence rates.

Indicator

B4

Deaths from lung cancer in men aged under 75 years

Background

Lung cancer is the commonest form of cancer in men, causing about 23,000 deaths a year in this group in England and Wales. It is estimated that at least 80 per cent of lung cancer is associated with smoking, but there are also important occupational and environmental risk factors, such as exposure to asbestos and air pollution. Long term survival of lung cancer is poor. Five years after diagnosis, only about 5 per cent of patients are still alive. Prevention, through the reduction of risk factors such as smoking, is therefore important.

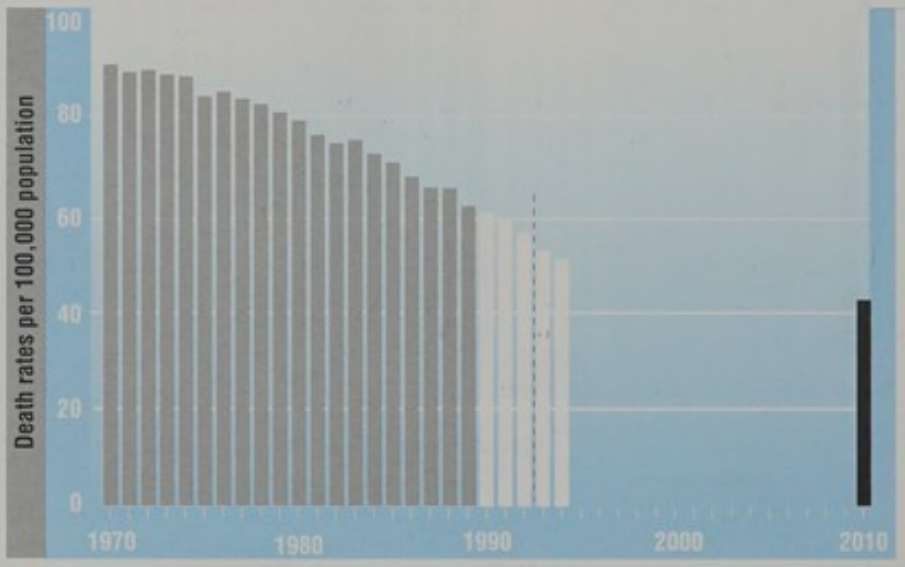
Target

To reduce the death rate from lung cancer in men aged under 75 years by at least 30 per cent by the year 2010, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
60.2	50.7	42.1

Comments

Death rates from lung cancer among men aged under 75 years have almost halved over the last two decades. The decline in death rates has been steady, and has continued since the Health of the Nation initiative began.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

B5

Deaths from lung cancer in women aged under 75 years

Background

Lung cancer is the second commonest form of cancer in women, causing about 11,000 deaths a year in this group in England and Wales. Prevention, through the reduction of risk factors such as smoking, is therefore important.

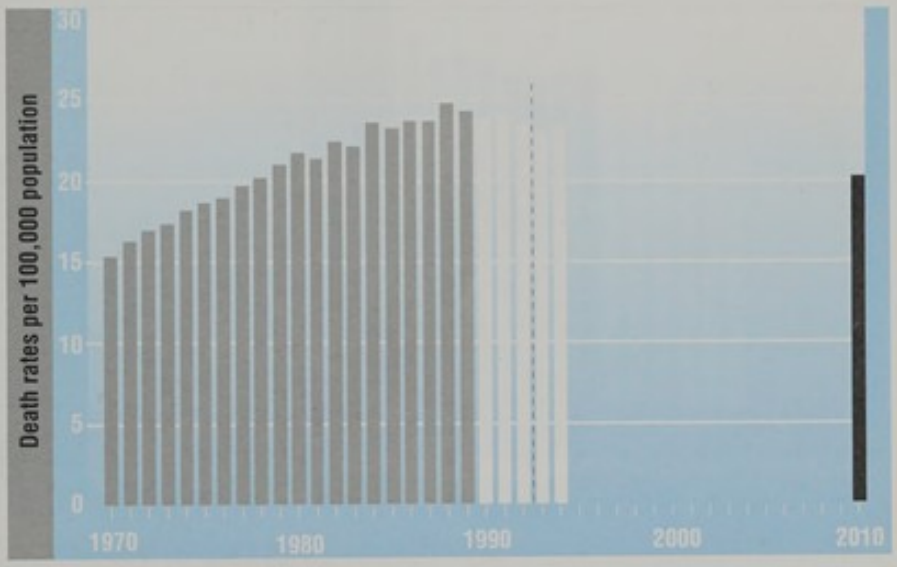
Target

To reduce the death rate from lung cancer in women aged under 75 years by at least 15 per cent by the year 2010, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2010)
23.8	23.4	20.2

Comments

While death rates from lung cancer among men have been declining, rates among women rose up until 1985. The rates have started to fall slowly, but there is no clear trend.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data.

Indicator

B7

Giving up smoking in pregnancy

Background

Smoking in pregnancy causes low birthweight, and increases the risks of foetal and neonatal morbidity and mortality. There is also evidence to link smoking in pregnancy with delays in the physical and mental development of the children concerned.

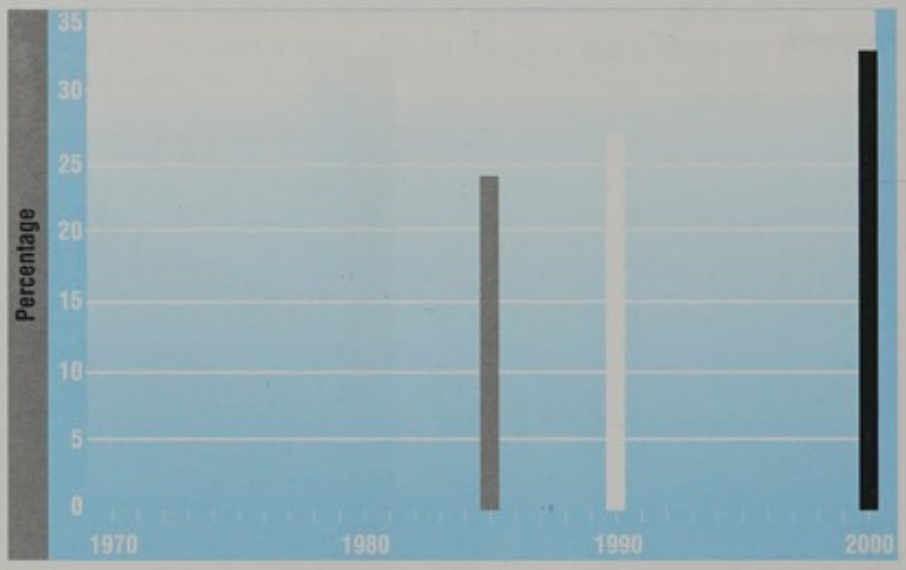
Target

To increase the percentage of women who stop smoking at the start of their pregnancy by at least one third by the year 2000.

Measure

Percentage of women stopping smoking at start of pregnancy as percentage of all those becoming pregnant who smoke.

Progress



Baseline (1985)	Latest available data (1990)	Target (2000)
24	27	33

Comments

Since the proportion of women who smoke is falling slowly (see indicator A5/B6), it may prove increasingly difficult to persuade those who continue to smoke to give up during pregnancy. However, too little data are available to make any judgement about progress. The Common Information Core of data has been amended to include annual information on the number of women smokers giving up before or during pregnancy from 1997/98.

Technical notes

Data have been drawn from the OPCS Infant Feeding Survey. No data are available before 1985. The data from the survey cover Great Britain, rather than England. Available data predate the start of the Health of the Nation strategy.

Indicator

B8

Consumption of cigarettes

Background

Smoking is an important risk factor for a wide range of diseases. This ill health and mortality can largely be prevented if people smoke less, stop smoking or do not start smoking in the first place.

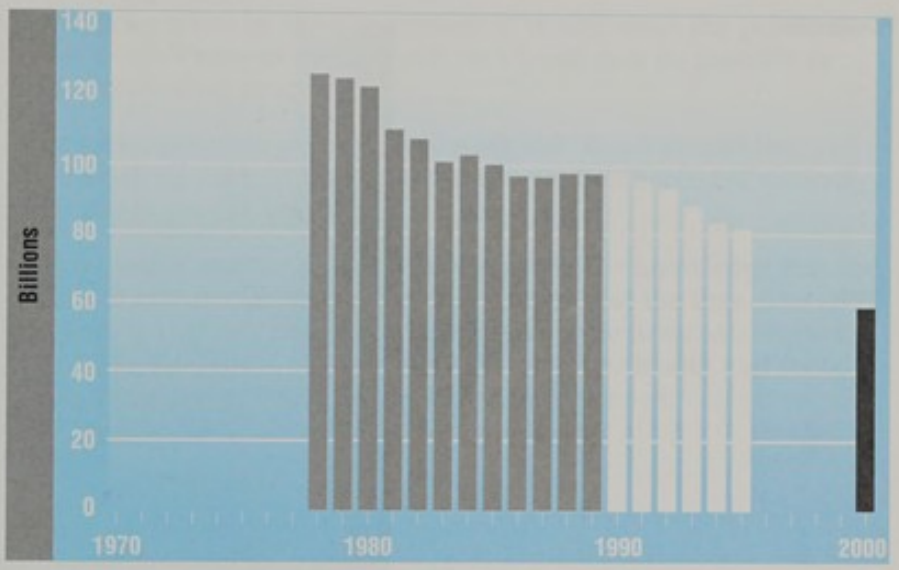
Target

To reduce the consumption of cigarettes by at least 40 per cent by the year 2000, from the 1990 baseline rate.

Measure

Billions of manufactured cigarettes released for home consumption per annum.

Progress



Baseline (1990)	Latest available data (1994-95)	Target (2000)
98.0	83.2	58.8

Comments

The consumption of cigarettes has fallen, in line with the decline in the proportion of people smoking (see indicator A6/B5). There has been a marked drop over the last five years, though some of this drop may be overstated due to the increased importation of cigarettes from other EU countries under the Single Market.

Technical notes

Data have been drawn from HM Customs and Excise statistics. Figures for 1982 onwards are for years ending June, while those for 1978 to 1981 are for calendar years. Data were not collected in this form before 1978. Data from 1993 onwards may not be comparable with previous years because of the impact of the EU Single Market.

Indicator

B9

Cigarette smoking in children aged 11-15 years

Background

Ill health and mortality resulting from smoking can largely be prevented if people stop smoking or do not start smoking in the first place.

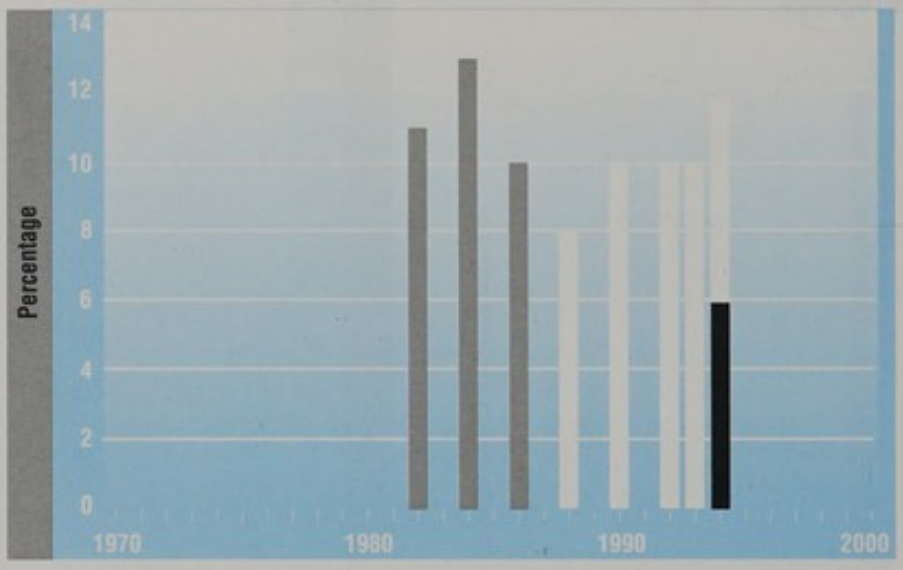
Target

To reduce the prevalence of cigarette smoking among children aged 11-15 years by at least 33 per cent by 1994, from the 1988 baseline rate.

Measure

Percentage of children aged 11-15 years who smoke regularly.

Progress



Baseline (1988)	Latest available data (1994)	Target (1994)
8	12	6

Comments

Although the rate of smoking among children aged 11-15 years appeared to fall during the 1980s before the Health of the Nation initiative, more recent data shows that it is now rising and in 1994 it was twice the target figure. With hindsight it is clear that 1988, taken as a baseline year, was a low point. This suggests that the actions taken or co-ordinated by the Department of Health to reduce smoking among children have not been successful.

Technical notes

Data have been drawn from the OPCS Schoolchildren's Smoking Survey. This survey only started in 1982, and so no data are available prior to that date.

Indicator

C1

Health and social functioning of mentally ill people

Background

Mental illness accounts for about 14 per cent of NHS inpatient costs and 23 per cent of pharmaceutical expenditure. It is the reason for about 14 per cent of certificated sickness absence from work. The commonest forms are depression, anxiety and dementia. Less common, but generally more severe, are psychotic illnesses such as schizophrenia and affective psychosis.

Target

To improve significantly the health and social functioning of mentally ill people.

Measure

Work undertaken by the Department of Health since the publication of the White Paper in 1992 means that it will now be possible to begin monitoring progress.

Progress

At present, progress towards achieving this target cannot be monitored, as data on the health and social functioning of mentally ill people is not yet available.

Comment

This indicator and target were adopted with the knowledge that the means to monitor progress were not available at the time. The OPCS National Psychiatric Morbidity Survey has since been established, and the development of instruments to measure health and social functioning among the mentally ill has been funded.

Technical notes

None.

Indicator

C2

Suicides in people of all ages

Background

Suicide accounts for about about 4,400 deaths a year in England (provisional data for 1994), or about 1 per cent of all deaths that occur. It is a major cause of premature death, and is the second commonest cause of death in men aged 15 to 34 years. Two thirds of people who commit suicide have consulted their GP in the previous month, a third of those have expressed clear suicidal intent, and a quarter of those are psychiatric outpatients. Suicide can be prevented by early intervention, supervision and social support.

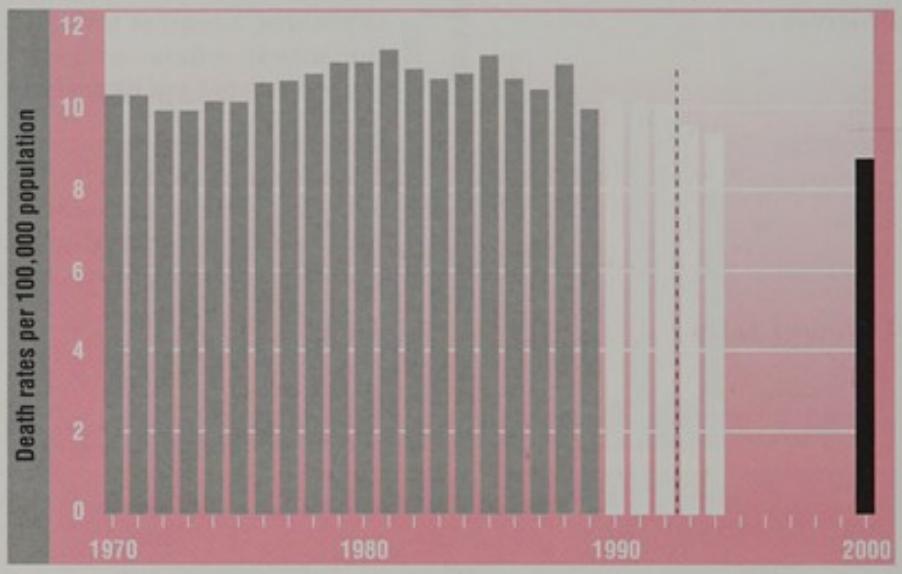
Target

To reduce the overall suicide rate in people of all ages by at least 15 per cent by the year 2000, from the 1990 baseline rate.

Measure

Suicide rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
10.4	9.5	8.8

Comments

The suicide rate has not changed greatly for the last two decades, although since 1985 there has been a consistent but gradual decline. In 1993 and 1994, quite marked falls were recorded, though they might be in part due to the changes in coding procedures referred to below.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data. These changes may have particularly affected the data for deaths from external causes, such as suicides and accidents.

Indicator

C3

Suicides in people who are severely mentally ill

Background

It is estimated that between 10 per cent and 15 per cent of people with serious mental illness end their own lives. Suicide can be prevented by early intervention, supervision and social support.

Target

To reduce the overall suicide rate in people who are severely mentally ill by at least 33 per cent by the year 2000, from the estimated 1990 baseline rate.

Measure

Percentage (number of suicides by people who are severely mentally ill as a percentage of the number of people with severe mental illness).

Progress

At present, progress towards achieving this target cannot be measured, as the necessary data on the prevalence and severity of mental illness in the general population are not available. Data in the 1996/97 Common Information Core will give a partial measure of this target. First figures should be available in the summer of 1997.

Baseline (1990)	Latest available data (1990)	Target (2000)
15 estimated	n/a	10

Comments

This indicator and target were adopted with the knowledge that the means to monitor progress were not available at the time. The OPCS National Psychiatric Morbidity Survey has since been established, but a working definition of severe mental illness has yet to be agreed.

Technical notes

None.

Indicator

D1

Incidence of gonorrhoea among people aged 15-64 years

Background

The target for gonorrhoea is intended to provide some indication of trends towards safe sexual behaviour, such as the use of condoms, which are likely to reduce the incidence of a range of sexually transmitted diseases. The target is particularly important as a marker of changes in behaviour likely to limit the sexual transmission of HIV/AIDS.

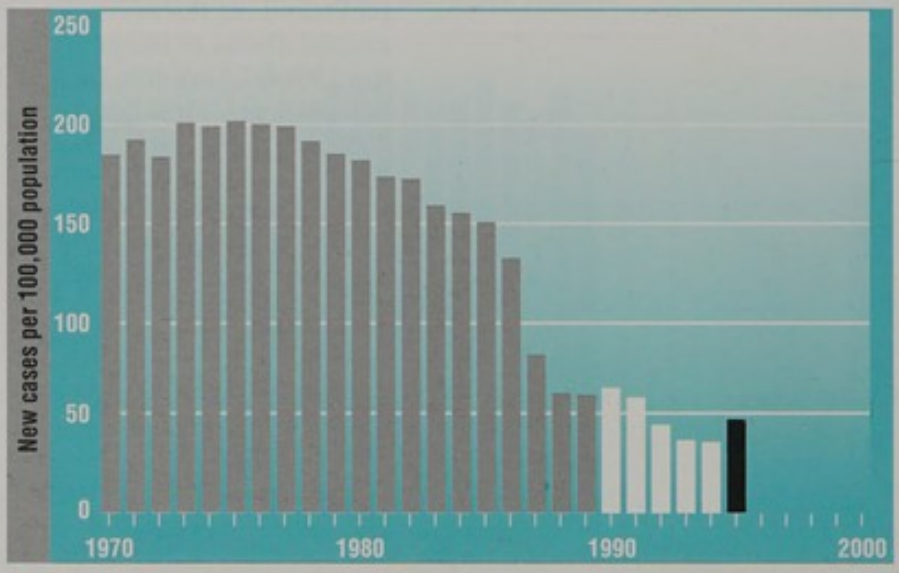
Target

To reduce the incidence of gonorrhoea among people aged 15-64 by at least 20 per cent by the year 1995, from the 1990 baseline rate.

Measure

New cases of gonorrhea per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (1995)
64.3	36.6	48.8

Comments

The incidence of gonorrhoea has fallen to less than a fifth of the level of two decades ago. This decline started around 1977, but accelerated during the 1980s. The target was met in 1992, and since.

Technical notes

Data have been drawn from returns to the Department of Health from genitourinary medicine clinics. It should be noted that a small percentage of patients may be seen and treated elsewhere, and so will not be included in these statistics, though this should not affect the use of data for monitoring trends.

Indicator

D2

Drug misusers who share injecting equipment

Background

Of the number of individual users who presented to drug agencies for the first time, or after an absence of at least six months, 42% of those whose injecting status was known reported that they were injecting their main drug. Sharing injecting equipment therefore represents an important mode of transmission for HIV/AIDS.

Target

To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous four weeks by at least 50 per cent by 1997, and by at least a further 50 per cent by the year 2000, from the 1990 baseline rate (that is from 20% in 1990 to no more than 10% in 1997 and no more than 5% by the year 2000).

Measure

Percentage of injecting drug misusers who report sharing injecting equipment in the previous four weeks.

Progress

At present, progress towards achieving this target is not being monitored in a way which is comparable with the 1990 baseline. The PHLS Unlinked Anonymous HIV Seroprevalence Monitoring Programme and a number of local surveys suggest that progress has been made towards meeting the target.

Comments

This indicator and target were adopted with the knowledge that the means to monitor progress were not available at the time. Arrangements have been made to collect data on the sharing of injecting equipment in regional drug misuse databases, which record new attendances at a range of drug misuse services.

The Department of Health is commissioning methodological work from the Centre for Research on Health and Health Behaviour in preparation for a major survey of drug misusers in 1997 which will be comparable with the 1990 baseline and will provide additional information on drug misusers who are not in contact with treatment services.

Technical notes

None.

Indicator

D3

Conceptions among girls aged under 16

Background

Pregnancy and childbirth among girls aged under 16 carries significant risks to their own health and that of their children. It is also likely to disrupt and adversely affect their education and normal social development. Unplanned conceptions in this group can be prevented through sex education, social support, attitudinal change and family planning services.

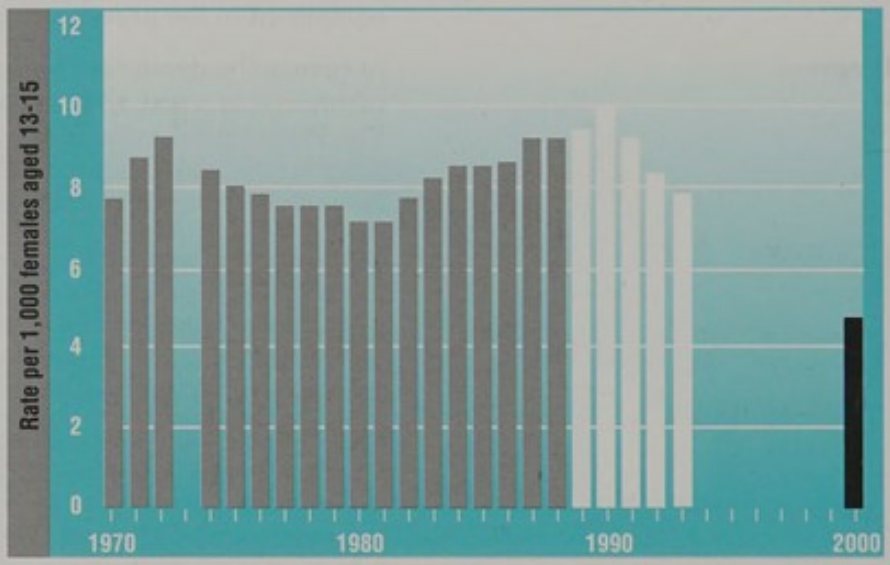
Target

To reduce the rate of conceptions among girls aged under 16 by at least 50 per cent by the year 2000, from the 1989 baseline rate.

Measure

Rate per 1,000 population per annum. The base population for the rate is girls aged 13-15 years.

Progress



Baseline (1989)	Latest available data (1993)	Target (2000)
9.5	8.0	4.8

Comments

Conception rates among girls aged under 16 years have fluctuated in the past, and peaked in the early 1970s and late 1980s. However, sharp falls in conception rates were recorded in 1991, 1992 and 1993 suggesting the start of a downward trend.

Technical notes

Data have been drawn from OPCS birth statistics, and include all live births, stillbirths and abortions under the 1967 Act involving girls aged under 16 at the estimated time of conception. They do not include spontaneous abortions. No data are available for 1973.

Indicator

E1

Deaths from accidents among children aged under 15 years

Background

Accidents are a major cause of avoidable injury and death, especially among children aged under 15 for whom accidents are the commonest single cause of death. Accidents result in about 10,000 deaths each year in England, or about 2 per cent of all deaths. About 500 of these deaths are among children. The treatment and care of those injured in accidents is believed to account for about 8.3 per cent of NHS expenditure. Although the UK has lower death rates for accidents than most other European countries, experience suggests that preventive action such as road safety measures and public education, combined with better medical treatment for those involved in accidents can reduce the ill health and morbidity involved.

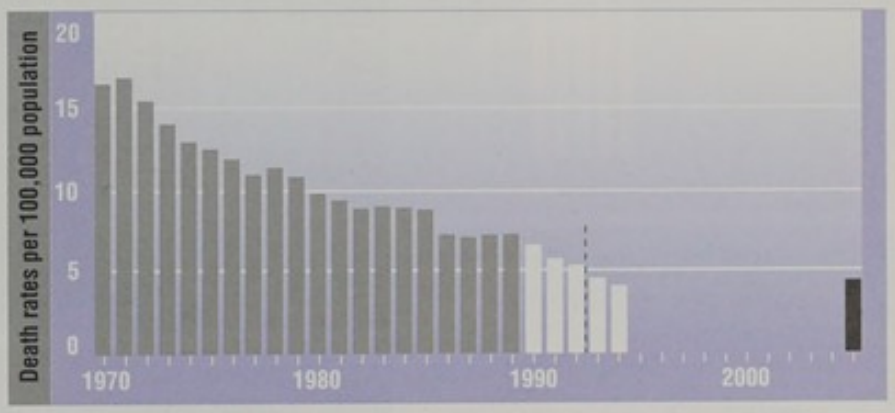
Target

To reduce the death rate for accidents among children aged under 15 years by at least 33 per cent by the year 2005, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2005)
6.8	4.2	4.5

Comments

Death rates from accidents among children aged under 15 years have been declining steadily for the last two decades, and this decline has continued since the Health of the Nation initiative was launched. The fall has been particularly marked in the last two years, but that may be in part due to the changes in coding procedures mentioned below. It appears that the target has already been met but this cannot yet be confirmed.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data. These changes may have particularly affected the data for deaths from external causes, such as suicides and accidents.

Indicator

E2

Deaths from accidents among people aged 15 to 24 years

Background

Almost 50 per cent of deaths in men and 30 per cent of deaths in women in the 15 - 24 years age group result from accidents. The single largest cause of accidental death for this group is road traffic accidents. There are about 1,000 deaths from accidents each year in the 15 - 24 years age group.

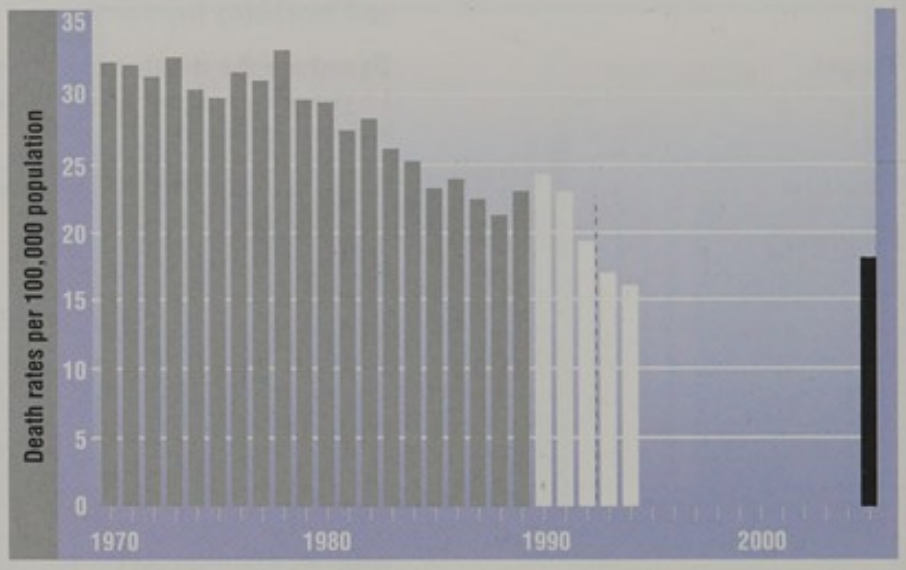
Target

To reduce the death rate for accidents among people aged 15 - 24 years by at least 25 per cent by the year 2005, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2005)
23.9	15.9	17.9

Comments

Death rates from accidents among people aged 15-24 years have been declining steadily for the last two decades, apart from an atypical peak in the late 1980s. Since 1990 this decline has continued. The fall has been particularly marked in 1992 and 1993, but that may be in part due to the changes in coding procedures mentioned below. It appears that the target has been met but this cannot yet be confirmed.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data. These changes may have particularly affected the data for deaths from external causes, such as suicides and accidents.

Indicator

E3

Deaths from accidents among people aged 65 years and over

Background

Accidents are a major cause of avoidable injury and death, especially among the elderly.

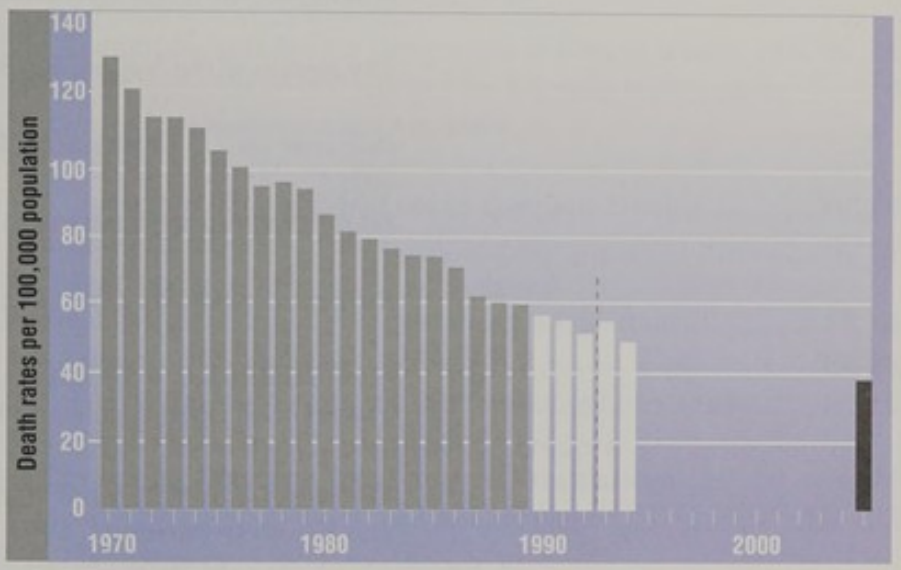
Target

To reduce the death rate for accidents among people aged 65 years and over by at least 33 per cent by the year 2005, from the 1990 baseline rate.

Measure

Death rate per 100,000 population per annum.

Progress



Baseline (1990)	Latest available data (1994)	Target (2000)
56.0	48.5	37.5

Comments

Death rates from accidents among the elderly have been declining steadily for the last two decades, apart from some occasional fluctuation from year to year. Since the start of the Health of the Nation initiative this decline has continued. The rise in 1993 (when the coding changes would have been expected to result in a fall) was surprising but appears since to have been reversed.

Technical notes

Data have been drawn from OPCS mortality statistics and age-standardised. Due to recent changes in the way deaths have been recorded and coded, the figures for 1993 onwards are not directly comparable with earlier data. These changes may have particularly affected the data for deaths from external causes, such as suicides and accidents.

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The Comptroller and Auditor General has to date, in Session 1995-96, presented to the House of Commons the following reports under Section 9 of the National Audit Act, 1983:

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